

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10133**  
**10147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **67**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files. Your file number is **10147**. BURIAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with your registrar prior to burial, cremation, or removal.

|  |                           |  |                                       |   |   |   |      |                                |                     |
|--|---------------------------|--|---------------------------------------|---|---|---|------|--------------------------------|---------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Caroline</b> MARYLAND  |                           |  |                                       | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> |   |   |      |                                |                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hickman</b>   |                           | c. LENGTH OF STAY IN lb<br><b>life</b>   |                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hickman</b>  |   | d. STREET ADDRESS   |      |                                |                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |                           |  |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |      |                                |                     |
| 3. NAME OF DECEASED (Type or print)<br><b>ARTHUR</b>   |                           | First  | Middle                                | Last  | 4. DATE OF DEATH<br><b>Oct. 8, 1956</b>       | Month   | Day  | Year                           |                     |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Aug. 20, 1891</b> |   | 9. AGE (in years last birthday) <b>65</b> yr. | IF UNDER 1 YEAR<br>Months   | Days | IF UNDER 24 HRS.<br>Hours Min. |                     |
| 10a. USUAL OCCUPATION (Give kind of work done during month of working life, even if retired)<br><b>Farm hand</b>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>   |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>A.S.A.T.</b>                   |      |                                |                     |
| 13. FATHER'S NAME<br><b>John Breeding</b>  |                           | 14. MOTHER'S MAIDEN NAME<br><b>Lottie Calloway</b>   |                                       |   |   |   |      |                                |                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                           | 16. SOCIAL SECURITY NO.  |                                       | 17. INFORMANT<br><b>Mrs. Eddie Breeding, Dayton</b>   |   | Address   |      |                                |                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO<br><b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Thrombosis</b> DUE TO<br>(c)   |                           |  |                                       |   |   |   |      |                                |                     |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hr.</b>  |                           |  |                                       |   |   |   |      |                                |                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |  |                                       |   |   |   |      |                                |                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |   |   |   |      |                                |                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour<br>a. m. <b>19</b><br>p. m.   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) <b>Concord</b>                                |      | (County) <b>Ind.</b>           | (State) <b>Ind.</b> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                           |  |                                       |   |   |   |      |                                |                     |
| ACTUAL SIGNATURE<br><b>Dawson O. George</b>  |                           | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                       | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED<br><b>10/10/56</b>                                    |      |                                |                     |
| EXAMINER'S NAME (Type)<br><b>Dawson O. George</b>  |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                                       |   |   |   |      |                                |                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                           | 22b. DATE THEREOF<br><b>Oct 11, 1956</b>   |                                       | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Concord</b>  |   | 22d. LOCATION (City, town, or county) <b>Concord Ind.</b> (State) |      |                                |                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. V. Moore, Jr., Dalton</b>  |                           | ADDRESS<br><b>111 N. Howard St., Baltimore, Md.</b>  |                                       | 24a. REC'D. BY REGISTRAR<br><b>10/10/56</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>M. D. O. George</b>              |      |                                |                     |

BUREAU Y.

OCT 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10-19

## CERTIFICATE OF DEATH

10134

Reg. Dist. No.

|   |                                  |   |  |  |   |   |                                     |         |
|---|----------------------------------|---|--|--|---|---|-------------------------------------|---------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Caroline</b>   |                                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b> |   | b. COUNTY<br><b>Caroline</b>  |                                     |         |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Preston</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Preston</b>                   |   |   |                                     |         |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                                  |   |  | d. STREET ADDRESS  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                     |         |
| 3. NAME OF DECEASED (Type or print)<br><b>Lloyd</b>   |                                  | First   | Middle   | Last   | 4. DATE OF DEATH<br><b>October 13 1956</b>        | Month   | Day                                 | Year    |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                           | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 5, 1897</b>  | 9. AGE (In years lost birthday)<br><b>59 yrs.</b> | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HRS.<br>Days Hours Min. |         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Roller Rink Owner</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Skating Rink</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Caroline Co., Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |         |
| 13. FATHER'S NAME<br><b>John E. Brodes</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Edith Bryan</b>  |  |  |   |   |                                     |         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-32-6977</b>   |  | 17. INFORMANT<br><b>Mrs. Elma T. Brodes, Preston, Maryland</b>   |   | Address   |                                     |         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>Generalized Circumferent</b>   |                                  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6mo</b>  |                                     |         |
| 163X<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-<br>lying cause last.<br><b>Carcinoma. F lung left</b>  |                                  | (b)<br>DUE TO<br><b>Branches of asthma.</b>   |  | (c)<br>DUE TO  |   | <b>12 hrs</b>   |                                     |         |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                     |         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]                    |  |  |   |   |                                     |         |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m.   |                                  | 20d. INJURY OCCURRED<br>White<br>at work <input type="checkbox"/> Not white<br>at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town)<br>(County)   |                                     | (State) |
| 21. I certify that I attended the deceased from <b>12/12</b> , 19 <b>55</b> to <b>October 13</b> , 19 <b>56</b> that I last saw the deceased alive on <b>10/14</b> , 19 <b>56</b> , and that death occurred at <b>1:20 AM</b> , from the causes and on the date stated above. |                                  |   |  |  |   |   |                                     |         |
| ACTUAL SIGNATURE<br><b>Harold B. Plummer</b>  |                                  |   |  | ADDRESS (Street, city or town, state)<br><b>Preston Maryland</b>   |   | DATE SIGNED<br><b>10/13/56</b>  |                                     |         |
| PHYSICIAN'S NAME (Type)<br><b>Harold B. Plummer, M.D.</b>   |                                  |   |  |  |   |   |                                     |         |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Oct. 16, 1956</b>   |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Junior Order Cemetery</b>   |   | 22d. LOCATION (City, town, or county)<br><b>Linchester, Maryland</b>                              |                                     | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>  |                                  | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>10-13-56</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Corneia D. Plummer</b>   |                                     |         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH-ENVIRONMENTAL

CERTIFICATE OF DEATH

SEARCHED

INDEXED

SERIALIZED

FILED

RECEIVED  
FEBRUARY 25

OCT 17 1956

RECEIVED  
FEBRUARY 25

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10135

10149

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

|  |                              |   |  |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Caroline   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><br>Maryland   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><br>Rural Henderson  |                              | c. LENGTH OF STAY IN 1b<br>50 Yrs.  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><br>None   |                              | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br><br>Henry   |                              | First<br><br>Brown  | Middle<br><br>Last<br><br>Month<br><br>Day<br><br>Year<br><br>10 7 19 56 |
| S. SEX<br><br>Male   | 6. COLOR OR RACE<br><br>Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><br>5/20/1905  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><br>Farm Laborer  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><br>None   |  |
| 11. BIRTHPLACE (State or foreign country)<br><br>Maryland  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><br>U.S.A.  |  |
| 13. FATHER'S NAME<br><br>William Brown   |                              | 14. MOTHER'S MAIDEN NAME<br><br>Annie Mason   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><br>No   |                              | 16. SOCIAL SECURITY NO.<br><br>Blanche Lecke  |  |
| 17. INFORMANT<br><br>Henderson, Md.  |                              | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><br>157X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><br>DUE TO<br><br>(b)<br><br>(c)     |                              | INTERVAL BETWEEN ONSET AND DEATH<br><br>4 mos 01  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |                              | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><br>Sent. 10 19 56, to Oct. 7 19 56  |                              | 20f. (City or town)<br><br>Greensboro, Md.  |  |
| (County)   |                              | (State)   |  |
| 21. I certify that I attended the deceased from alive on<br>8ct. 6, 19 56, and that death occurred at 3A.  |                              | that I last saw the deceased<br>ADDRESS (Street, city or town, state)<br>DATE SIGNED<br>10/8/56   |  |
| ACTUAL SIGNATURE<br><br>Charles H. Stonesifer  |                              | M.D.  |  |
| PHYSICIAN'S NAME (Type)<br><br>Charles H. Stonesifer   |                              |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                              | 22b. DATE THEREOF<br>10/10/56   |  |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br>Union  |                              | 22d. LOCATION (City, town, or county)<br>Goldsboro. Md.   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><br>E. Boulaire Greensboro Md.   |                              | 24a. REC'D BY REGISTRAR<br>DATE 10/12/56  |  |
|  |                              | 24b. REGISTRAR'S SIGNATURE<br>AC Smith  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

财智精英-10强企业领导力修炼手册

OCT 17 1956

OCT 17 1950

REGGIE ED

**INSTRUCTIONS**

**PRINTING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-153 10W

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

10150

**CERTIFICATE OF DEATH**

10136

Reg. Dist. No. ....

**1. PLACE OF DEATH**

COUNTY

Caroline

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR TOWN and give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Rural Denton

LENGTH OF STAY  
(in this place)

10 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE

Md

COUNTY

Caroline

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET  
ADDRESS

Rural Denton

**3. NAME OF  
DECEASED**  
(Type or Print)

(First) Margaret

(Middle)

(Last)

**4. DATE  
OF  
DEATH**

Oct 5 1956

5. SEX

F

6. COLOR OR  
RACE

N

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

Divorced

8. DATE OF BIRTH

Oct 15, 1864

9. AGE last birthday

92

yrs.

IF UNDER 1 YEAR

Months

Deys

IF UNDER 24 HRS.

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Housewife

10b. KIND OF BUSINESS  
OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

USA

13. FATHER'S NAME

Samuel Hutchins

14. MOTHER'S MAIDEN NAME

Rockie Shepherd

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

**8. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

33IX IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE(S) DUE TO

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

**18. MEDICAL CERTIFICATION**

Cerebral Hemorrhage.

Hypertension

arteriosclerosis

INTERVAL BETWEEN  
ONSET AND DEATH

7 days

?

?

?

**11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21c. WHERE DID INJURY OCCUR? (City or town)  
(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While  Not while  
at work  at work 

21f. HOW DID INJURY OCCUR?

M.

19. I hereby certify that I attended the deceased from

alive on Oct 4, 1956, and that death occurred at 11 P.M. from the causes and on the date stated above.  
SIGNATURE H. L. Small

ADDRESS (Street, city, town, state)

DATE SIGNED Oct 8, 1956

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

DATE THEREOF

Oct 9, 1956

NAME OF CEMETERY OR CREMATORI

Spring Grove

LOCATION (City, town, or county)

Denton Md.

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE 10.9.56

Md. George J. Virgil Knottson Denton

RECEIVED - DEPARTMENT OF STATE - WASH. 25, D. C.

CERTIFICATE OF SERVICE

RECEIVED - DEPARTMENT OF STATE - WASH. 25, D. C.

RECEIVED - DEPARTMENT OF STATE - WASH. 25, D. C.

BUREAU U. S.

OCT 15 1956

RECEIVED

W.W.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10151

## CERTIFICATE OF DEATH

10137

Reg. Dist. No.

62

|  |   |  |   |  |   |   |  |   |
|--|---|--|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><i>Caroline</i>  |   | MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE<br><i>Maryland</i> |   | b. COUNTY<br><i>Caroline</i>  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rural Preston, Harmony</i>  |   | c. LENGTH OF STAY IN 1b<br><i>2 yrs</i>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rural Preston, Harmony</i>    |   | d. STREET ADDRESS   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |   |  |   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 3. NAME OF DECEASED<br>(Type or print)   |   | First<br><i>SAM</i>  | Middle<br><i>SLIP</i>   | Last<br><i>DELOATCH</i>  | 4. DATE OF DEATH<br><i>Oct. 7 1956</i>    | Month<br><i>Oct.</i>  | Day<br><i>7</i>                          | Year<br><i>1956</i>   |
| S. SEX<br><i>M</i>   | 6. COLOR OR RACE<br><i>N</i>              | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>unknown</i>  | 9. AGE (In years last birthday)<br><i>61 yrs.</i>  | 10. IF UNDER 1 YEAR<br>Months<br><i>0</i> | 11. IF UNDER 24 HRS.<br>Hours<br><i>0</i>   | 12. IF UNDER 24 HRS.<br>Min.<br><i>0</i> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Psy LABORER</i>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>FARMING</i>  |   | 11. BIRTHPLACE (State or foreign country)<br><i>North Carolina</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |   |
| 13. FATHER'S NAME<br><i>John DeLoatch</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Rose</i>  |   |  |   |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><i>yes</i>  |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><i>Richard DeLoatch, 2707 Marlboro St<br/>Portsmouth, Va.</i>                                       |   | Address   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><i>023X</i>  |   | DUE TO<br><i>Acute reperfusion and stroke</i>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 years</i>   |   |   |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)  |   | DUE TO<br><i>Syphilis -</i>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>20 years.</i>   |   |   |  |   |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |  |   |  |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY<br>Hour<br>o. m.<br>p. m.  | Month<br>19                               | Day  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)<br><i>Denton</i>      | (County)<br><i>Debtton</i>  | (State)<br><i>Md.</i>                    |   |
| 21. I certify that I attended the deceased from <i>March 9, 1954</i> , to <i>Oct 7, 1956</i> , that I last saw the deceased alive on <i>Oct. 5, 1956</i> , and that death occurred at <i>4A M.</i> , from the causes and on the date stated above. |   |  |   |  |   |   |  |   |
| ACTUAL SIGNATURE<br><i>E. Paul Knotts</i>  |   | ADDRESS (Street, city or town, state)<br><i>Denton Md.</i>   |   |  |   |   |  | DATE SIGNED   |
| PHYSICIAN'S NAME (Type)<br><i>E. Paul Knotts M.D.</i>  |   | Debtton, Md  |   |  |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 22b. DATE THEREOF<br><i>Oct. 11, 1956</i> | 22c. NAME OF CEMETERY OR CREMATORIUM<br><i>Harmony</i>   |   | 22d. LOCATION (City, town, or county)<br><i>Harmony</i>  |   | (State)<br><i>Md.</i>   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>J. V. Knottson</i>  |   | ADDRESS<br><i>1118 George</i>  |   | 24a. REC'D BY REGISTRAR<br>DATE <i>10/11/56</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>J. V. Knottson</i>   |  |   |

BUREAU Y.

OCT 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10152

## CERTIFICATE OF DEATH

10138

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be reviewed by the hospital or attending physician.  
DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |   |  |  |  |  |  |
|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Caroline</b>   |   | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE<br><b>Maryland</b> |  | b. COUNTY<br><b>Caroline</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Preston - Rural</b>  |   | c. LENGTH OF STAY IN 1b<br><b>14 years</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Preston - Rural</b>           |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Jonestown</b>  |   | d. STREET ADDRESS<br><b>Jonestown</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>First Timothy M. Farmer</b>   | 4. DATE OF DEATH<br><b>Month October Day 28 Year 1956</b> |   |  |  |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b>                        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     | B. DATE OF BIRTH<br><b>August 18, 1896</b> | 9. AGE (in years last birthday)<br><b>60 yrs.</b>  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>0</b> | 11. IF UNDER 24 HRS<br>Hours <b>0</b> Min. <b>0</b>                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Minister</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Church of God in Christ</b>                                       |  | 11. BIRTHPLACE (State or foreign country)<br><b>Louisville, Ga.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                  |  |
| 13. FATHER'S NAME<br><b>Alex Farmer</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Frances (maiden name unknown)</b>  |  | Address  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)<br><b>Yes WW I</b>  |   | 16. SOCIAL SECURITY NO.<br><b>260-05-1368</b>   |  | 17. INFORMANT<br><b>Mrs. Willie Farmer, Preston, Md., R.F.D.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   | Acute Coronary Occlusion  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hours</b>   |  |  |  |
| (b)<br>DUE TO   |   | Arteriosclerotic heart Disease  |  | 10 years   |  |  |  |
| (c)   |   | Generalized Arteriosclerosis  |  | 10 years   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.   |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State)    |  |  |  |
| 21. I certify that I attended the deceased from <b>9/20/43</b> , 19_____, to <b>10/28/56</b> , 19_____, that I last saw the deceased alive on <b>10/28/56</b> , 19_____, and that death occurred at <b>10:25 A.M.</b> from the causes and on the date stated above.<br>ACTUAL SIGNATURE<br><i>Harold B. Plummer</i> |   | ADDRESS (Street, city or town, state)<br><b>Preston, Maryland</b>   |  | DATE SIGNED<br><b>10/11/56</b>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>Harold B. Plummer, M.D.</b>   |   | Preston, Maryland   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>Nov. 3, 1956</b>  |  | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Church of God in Christ</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Near Preston, Maryland</b> (State) |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>  |   | ADDRESS<br><b>J.J. Frampton and Son, Federalsburg, Maryland</b>   |  | 24a. REC'D BY REGISTRAR<br><b>DATE 10/11/56</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Cornelia N. Plummer</b>                       |  |

BUREAU V. S.

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RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10139

10153

## CERTIFICATE OF DEATH

Reg. Dist. No.

66

|   |                         |  |   |
|---|-------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                         | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE  |   |
| Caroline MARYLAND   |                         | Maryland b. COUNTY Caroline  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   |
| Rural Ridgely   | 11 Yrs.                 | Rural Ridgely  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  | d. STREET ADDRESS       |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |
| Johns Nursing Home  | None                    |  |   |
| 3. NAME OF DECEASED (Type or print)   | First Jessie            | Middle Johnson   | 4. DATE OF DEATH  |
| 5. SEX  | 6. COLOR OR RACE        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH  |
| Male  | Col.                    | 7-23-93  | 9. AGE (In years last birthday) 82 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)   |
| Farm Laborer  |                         | None   | Virginia  |
| 13. FATHER'S NAME   |                         | 14. MOTHER'S MAIDEN NAME   |   |
| No Record   |                         | No Record  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                         | 16. SOCIAL SECURITY NO.  | 17. INFORMANT   |
| No  |                         | None   | Johns Nursing Home, Ridgely, Md.  |
| Address   |                         |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |                         | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)   |                         | 'acute perforated ap endix with peritonitis'   |   |
| 550.1<br>DUE TO   |                         |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                         |  |   |
| (b)   |                         |  |   |
| DUE TO  |                         | Partial intestinal obstruction   |   |
| (c)   |                         |  |   |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                         | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19 p. m.   |                         | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town)<br>(County) (State) |
| 21. I certify that I attended the deceased from June 15, 1956, to Oct. 6, 1956, that I last saw the deceased alive on Oct. 5, 1956, and that death occurred at 9:30 P.M., from the causes and on the date stated above. |                         | ADDRESS (Street, city or town, state) DATE SIGNED<br>Towson, Md. 10/8/56   |   |
| ACTUAL SIGNATURE Charles H. Stover, M.D.  |                         |  |   |
| PHYSICIAN'S NAME (Type)   |                         | Charles H. Stover, M.D.  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |                         | 22b. DATE THEREOF 10/8/56  | 22c. NAME OF CEMETERY OR CREMATORIALy   |
|   |                         | University Medical School Baltimore, Md.   |   |
| 22d. LOCATION (City, town, or county) (State)   |                         |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boelens Greensboro, Md.  |                         | ADDRESS  | 24a. REC'D BY REGISTRAR DATE 10-10-56   |
|   |                         | 24b. REGISTRAR'S SIGNATURE Mary E. Laird   |   |

BUKLEAU V.

• 000 15 1956

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10140

10154

## CERTIFICATE OF DEATH

Reg. Dist. No. 60

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, it may be retained by the hospital or attending physician.  
**TO REGISTRAR:** This certificate should be detached for use as the burial permit. Then please remove carbon paper sheet 1 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                           |   |                                   |  |   |  |   |
|--|---------------------------|---|-----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Caroline   |                           | MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)<br>a. STATE<br><br>Maryland |   | b. COUNTY<br><br>Caroline  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><br>Rural Henderson  |                           | c. LENGTH OF STAY IN lb<br><br>11 Yrs.  |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><br>Rural Henderson          |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><br>None  |                           | d. STREET ADDRESS<br><br>None   |                                   | e. IS RESIDENCE<br>ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |   |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br><br>Joseph  |                           | First   | Middle                            | Last   | Kotowski  | 4. DATE<br>OF<br>DEATH<br><br>10   | Month<br>9 Day<br>Year<br>1956          |
| 5. SEX<br>Male   | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><br>1/25/1890 |  | 9. AGE (In years<br>last birthday)<br><br>66 yrs. | 10. IF UNDER 1 YEAR<br>Months<br>Days  | 11. IF UNDER 24 HRS.<br>Hours<br>Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><br>Retired Marine Surveyor   |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |                                   | 11. BIRTHPLACE (State or foreign country)<br><br>Africa  |   | 12. CITIZEN OF WHAT COUNTRY?<br><br>U.S.A.   |   |
| 13. FATHER'S NAME<br><br>Lenord Kotowski   |                           | 14. MOTHER'S MAIDEN NAME<br><br>Louise Kotowski   |                                   |  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><br>Yes  |                           | 16. SOCIAL SECURITY NO.<br><br>1908-14-2857   |                                   | 17. INFORMANT<br><br>Edith Kotowski  |   | Address<br><br>Henderson, Md.  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br><br>162X  |                           | DUE TO<br><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br><br>(b)                          |                                   | INTERVAL BETWEEN<br>ONSET AND DEATH<br><br>CIRCUMSTANCES<br><br>6 mos  |   |  |   |
| DUE TO<br><br>(c)  |                           |   |                                   |  |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                           |   |                                   |  |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                   |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town)<br><br>Greensboro  | (County) (State)<br><br>Greensboro, Md. |
| 21. I certify that I attended the deceased from <u>July 30</u> , 1956, to <u>Oct 9</u> , 1956, that I last saw the deceased alive on <u>Oct 9</u> , 1956, and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. |                           |   |                                   |  |   | ADDRESS (Street, city or town, state)<br><br>Greensboro, Md.   |   |
| ACTUAL<br>SIGNATURE<br><br>Physician's<br>NAME (Type)<br><br>Robert Hill   |                           | M.D.  |                                   |  |   | DATE SIGNED<br><br>Oct 11 1956   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>10/13/56   |                                   | 22c. NAME OF CEMETERY OR CREMATORIAL<br>Greensboro   |   | 22d. LOCATION (City, town, or county)<br>Greensboro, Md. (State)                                     |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><br>J.E. Boes Louis  |                           | ADDRESS<br><br>Greensboro, Md.  |                                   | 24a. REC'D BY REGISTRAR<br>DATE 10/13/56   |   | 24b. REGISTRAR'S SIGNATURE<br>ao Smith   |   |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10155 CERTIFICATE OF DEATH

10141

Reg. Dist. No. 64

|   |                                  |   |   |  |  |
|---|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Caroline</b>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Caroline</b> |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>37 yrs.</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Federalsburg, Md.</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Holt Street</b>   |                                  |   | e. STREET ADDRESS<br><b>Holt St.</b>  |  |  |
| f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | First<br><b>Hattie E. Liden</b>  | Middle  | Last  | 4. DATE<br>OF<br>DEATH   | Month<br><b>Oct. 21, 1956</b> Day<br>Year<br><b>19</b>   |
| 5. SEX<br><b>fem.</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>June 24, 1879</b>  | 9. AGE (In years<br>last birthday)<br><b>77 yrs</b>  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months<br><b>0</b> Days<br><b>0</b> Hours<br><b>0</b> Min.<br><b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br><b>housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  |
| 13. FATHER'S NAME<br><b>Caleb Todd</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte Nichols</b>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><b>Mrs. Viola Robinson Federalsburg, Md.</b>                                     |  |
| 18. CAUSE OF DEATH [Enter only one cause per line] for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause first. } (b)<br>DUE TO<br>(c)<br>Acute Enteritis |                                  |   |   |  |  |
| INTERVAL BETWEEN<br>ONSET AND DEATH<br><b>2 weeks</b>   |                                  |   |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>General Arteriosclerosis + Senility</b>   |                                  |   |   |  |  |
| 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY<br>Hour<br>o. n.<br>p. m.   | Month, Day, Year<br><b>19</b>    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>Hurlock, Md.</b>   | (County)<br><b>Calvert Co.</b> (State)<br><b>Md.</b>   |
| 21. I certify that I attended the deceased from <b>Oct. 7, 1956</b> , to <b>Oct. 21, 1956</b> , that I last saw the deceased alive on <b>Oct. 20, 1956</b> , and that death occurred at <b>Hurlock, Md.</b> M, from the causes and on the date stated above.                                      |                                  |   |   |  |  |
| ACTUAL<br>SIGNATURE<br><b>W. Harrison</b>   |                                  |   |   |  |  |
| ADDRESS (Street, city or town, state)<br><b>Hurlock, Md.</b>  |                                  |   |   |  |  |
| DATE SIGNED<br><b>10/21/56</b>  |                                  |   |   |  |  |
| 22a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>burial</b>   |                                  | 22b. DATE THEREOF<br><b>Oct. 25, 1956</b>   |   | 22c. NAME OF CEMETERY OR CREMATORIUM<br><b>Bloomery Cemetery</b>   |  |
| 22d. LOCATION (City, town, or county)<br><b>near Federalsburg</b> (State)<br><b>Md.</b>   |                                  |   |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard W. Williams</b>   |                                  |   | 24a. REC'D BY REGISTRAR<br>DATE<br><b>Oct. 25, 1956</b>   |  |  |
| ADDRESS<br><b>Federalsburg, Md.</b>   |                                  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Margaret H. Chapman</b>  |  |  |

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

GRÉAU V. S.

REC'D 11 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10142

10155

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

|  |                           |   |                                |
|--|---------------------------|---|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Caroline   |                           | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)<br>a. STATE Maryland<br>b. COUNTY Caroline                             |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Greensboro   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Greensboro  |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>None  |                           | d. STREET ADDRESS<br>None   |                                |
|  |                           | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |
| 3. NAME OF<br>DECEASED<br>(Type or print)  | First<br>Susie            | Middle<br>M.  | Last<br>Pimm                   |
| 4. DATE<br>OF<br>DEATH   | Month<br>10               | Day<br>24   | Year<br>1956                   |
| S SEX<br>Female  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>12/23/1864 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   |                                |
| 11. BIRTHPLACE (State or foreign country)<br>New Jersey  |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                |
| 13. FATHER'S NAME<br>Alfred Meeker   |                           | 14. MOTHER'S MAIDEN NAME<br>Mary Sober  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) No   |                           | 16. SOCIAL SECURITY NO.<br>None   |                                |
| 17. INFORMANT<br>Walter B. Pimm Greensboro, Md.  |                           | Address   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>331X<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last. 904                             |                           | INTERVAL BETWEEN<br>ONSET AND DEATH<br>2 mos  |                                |
| (b)<br>DUE TO<br>(c)   |                           | 2 mos   |                                |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Fracture ft. Farmer 7-24-56  |                           |   |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m.<br>p. m. 19   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                           | 20f. (City or town)<br>(County) (State)   |                                |
| 21. I certify that I attended the deceased from 7-24, 1956, to 10-24, 1956, that I last saw the deceased<br>alive on 10-23, 1956, and that death occurred at 5 A. M., from the causes and on the date stated above.<br>ACTUAL<br>SIGNATURE<br>Physician's<br>NAME (Type)<br>Robert H. Wright, M.D. |                           |   |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 22b. DATE THEREOF<br>10/26/56   |                                |
| 22c. NAME OF CEMETERY OR CREMATORIUM<br>Rosedale   |                           | 22d. LOCATION (City, town, or county)<br>Orange, N.C. (State)   |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>F. E. Bourlaire, Greensboro, Md.   |                           | ADDRESS   |                                |
| 24a. REC'D BY REGISTRAR<br>DATE 10/26/56   |                           | 24b. REGISTRAR'S SIGNATURE<br>L. M. Lippman   |                                |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO BURIAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's records. It should be detached for use as the burial-trust permit. Then please remove carbon papers 1 once it is signed. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL V. S

NOV 3 1950

U.S. GOVERNMENT

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10143

10157

## CERTIFICATE OF DEATH

Reg. Dist. No.

60

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE   |   |
| Caroline MARYLAND   |  | Maryland  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  | c. LENGTH OF STAY IN 1b<br>Rural Goldsboro 26 Yrs. | b. COUNTY   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION None  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Goldsboro   |   |
| d. STREET ADDRESS None  |  | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)  | First Walter                                       | Middle Ross   | 4. DATE OF DEATH<br>Month 10 Day 11 Year 1956 |
| 5. SEX Male   | 6. COLOR OR RACE Col.                              | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>1/1/1905                  |
| 9. AGE (In years lost birthday) 51 yrs  | 10. IF UNDER 1 YEAR Months                         | 11. IF UNDER 24 HRS Days  | 12. IF UNDER 24 HRS Hours Min.                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Farm Laborer   |  | 10b. KIND OF BUSINESS OR INDUSTRY None  |   |
| 10c. BIRTHPLACE (State or foreign country) Maryland   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |   |
| 13. FATHER'S NAME Alexander Ross  |  | 14. MOTHER'S MAIDEN NAME Katherine Sparks   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>No  |  | 16. SOCIAL SECURITY NO. 215-18-4803 17. INFORMANT Mammie Ross Address Goldsboro, Maryland   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><br>DUE TO<br><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br><br>DUE TO<br><br>(c)   |  | INTERVAL BETWEEN ONSET AND DEATH<br><br>Coronary Disease<br><br>Atherosclerotic cardiovascular disease  |   |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><br>ADDRESS (Street, city or town, state)                   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19 p. m.   |  | 20d. INJURY OCCURRED<br>White Not white<br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from Oct. 15, 1955, to Oct. 21, 1956, that I last saw the deceased alive on Oct. 11, 1956, and that death occurred at 10:10 A.M. from the causes and on the date stated above.<br><br>ACTUAL SIGNATURE Charles H. Storer, M.D. ADDRESS (Street, city or town, state) Goldsboro, Md. DATE SIGNED Oct. 13, 1956. |  |   |   |
| PHYSICIAN'S NAME (Type) Charles H. Storer   |  | 22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 10/15/56 22c. NAME OF CEMETERY OR CREMATORIUM Union                                      |   |
| 22d. LOCATION (City, town, or county) (State) Near Goldsboro, Maryland  |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. Boenix Greensboro, N.C.   |  | 24a. REC'D BY REGISTRAR DATE 10/16/56 24b. REGISTRAR'S SIGNATURE A. C. Small  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Form 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGREV

OCT 1966

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10144

10-58

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH  
o. COUNTY

Caroline

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Denton

c. LENGTH OF STAY IN 1b

5 yrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Kingsley Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
o. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Kingsley Hospital

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES  NO 3. NAME OF DECEASED  
(Type or print)First NINA  
Middle CHESTER  
Last RYAN

4. DATE OF DEATH

Month Oct.  
Day 12  
Year 1956

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

9. AGE (In years  
from birthday)

June 9, 1876

80 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown J Ryan

14. MOTHER'S MAIDEN NAME

Eunice Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE

420.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.(b)  
DUE TO

(c)

Cardiac (Coronary) insufficiency

Coronary arterio sclerosis

INTERVAL BETWEEN  
ONSET AND DEATH  
2 wks

3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
While  Not while   
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Oct. 11, 1956, to Oct 11, 1956, that I last saw the deceased alive on Oct. 11, 1956, and that death occurred at 4 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

E.Paul Knotts

M.D.

Denton and

22a. BURIAL, CREMATION, OR REMOVAL (Specify)

Burial 10-16-56

22b. DATE THEREOF

10-16-56

22c. NAME OF CEMETERY OR CREMATORIUM

Forestville

22d. LOCATION (City, town, or county)

Forestville, N.J.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John Moore

ADDRESS

Denton

24a. REC'D BY REGISTRAR

Date 10/15/56

24b. REGISTRAR'S SIGNATURE

M. O. George

DEPARTMENT OF STATE - COMMUNIQUE - 10  
CERTIFICATE OF DEATH

BUREAU V. S.  
OCT. 19 1956  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10145

66

10:59

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |   |   |  |   |         |
|--|---|---|---|---|--|---|---------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><br>Caroline MARYLAND  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE Maryland b. COUNTY Caroline |   |  |   |         |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Ridgely  | c. LENGTH OF STAY IN 1b<br>70 Yrs.  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Rural Ridgely   |   |   |  |   |         |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br>None  | d. STREET ADDRESS<br>None   |   |   | e. IS RESIDENCE<br>ON A FARM<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |         |
| 3. NAME OF<br>DECEASED<br>(Type or print)<br>Florence  | First<br>Emma   | Middle<br>Young   | Lost  | 4. DATE<br>OF<br>DEATH<br>10 1  | Month Day Year<br>10 1 56<br>19                      |   |         |
| S. SEX<br>Female   | 6. COLOR OR RACE<br>Col.  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>10/9/1885   | 9. AGE (in years<br>lost/birthday)<br>70 yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.<br>0 0 0 0 |   |         |
| 10a. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)<br>Housewife  | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   | 11. BIRTHPLACE (State or foreign country)<br>Maryland   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  |   |         |
| 13. FATHER'S NAME<br>Solomon Hamond  | 14. MOTHER'S MAIDEN NAME<br>Mary ?  |   |   |   |  |   |         |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No   | 16. SOCIAL SECURITY NO.<br>220-03-3469  | 17. INFORMANT<br>Ella Berry Ridgely, Md.  | Address   |   |  |   |         |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>420.0<br>DUE TO<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the under-<br>lying cause last.<br>(b)<br>DUE TO<br>(c) |   |   | INTERVAL BETWEEN<br>ONSET AND DEATH<br>Please   |   |  |   |         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Osteoarthritis hyperrophic   |   |   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |   |  |   |         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |  |   |         |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19<br>p. m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br>Ridgely, Md.   | (County)  | (State)  |   |         |
| 21. I certify that I attended the deceased from June 6, 1956, that I last saw the deceased<br>alive on Oct. 21, 1956, and the death occurred at M., from the causes and on the date stated above.<br>CHARLES N. WINCOTT M.D.   |   |   |   | ADDRESS (Street, city or town, state)<br>Ridgely, Md.   | DATE SIGNED<br>10-25-56                              |   |         |
| ACTUAL<br>SIGNATURE<br>CHARLES N. WINCOTT  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |   |   | 22b. DATE THEREOF<br>10/5/56  | 22c. NAME OF CEMETERY OR CREMATORIUM<br>Denton,      | 22d. LOCATION (City, town, or county)<br>Denton, Maryland | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>F. E. Boulaire Greensboro, Md.   | ADDRESS   |   |   | 24a. REC'D BY REGISTRAR<br>DATE 10/4/56   | 24b. REGISTRAR'S SIGNATURE<br>Mary E. Laird          |   |         |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANUFACTURED STATE OF OREGON - CALIFORNIA - 19

CERTIFICATE OF AGENT

BUREAU Y. S.

OCT 8 1966

RECEIVED